Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC Chillicothe, OH - 538

VISN 10

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 75

2. Point-in-time estimate of Veterans who are Chronically Homeless: 21

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **75** (point-in-time estimate of homeless veterans in service area) **X 38%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 76%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 21** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	123	100
Transitional Housing Beds	26	50
Permanent Housing Beds	0	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Various communities are looking at implementing or expanding shelter services. The key is securing funding. There have been county-wide continuums developed in several areas in Southern Ohio to address the needs of homeless.
Long-term, permanent housing	Improving collaboration and communication to identify housing resources and access for veterans.
Transitional living facility	Expand local VA contract with community partners. Encourage VA Grant and Per Diem applications. Goodwill Industry is looking at leasing building space. Possible enhanced use project in FY 2005.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 41 Non-VA staff Participants: 35% Homeless/Formerly Homeless: 44%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.38	23%	2.25	1
2	Discharge upgrade	2.51	6%	2.90	15
3	Women's health care	2.55	0%	3.09	21
4	Glasses	2.58	6%	2.67	6
5	Welfare payments	2.58	0%	2.97	16
6	Child care	2.61	0%	2.39	3
7	Dental care	2.79	13%	2.34	2
8	Eye care	2.79	3%	2.65	5
9	Halfway house or transitional living facility	2.82	19%	2.76	8
10	Legal assistance	2.87	6%	2.61	4
11	Education	2.92	6%	2.88	13
12	Drop-in center or day program	2.95	6%	2.77	10
13	SSI/SSD process	2.95	10%	3.02	19
14	Emergency (immediate) shelter	3	23%	3.04	20
15	Guardianship (financial)	3	3%	2.76	9
16	Job training	3.18	0%	2.88	14
17	VA disability/pension	3.19	3%	3.33	29
18	Help with finding a job or getting employment	3.21	19%	3.00	17
19	Help managing money	3.26	0%	2.71	7
20	Help getting needed documents or identification	3.29	6%	3.16	23
21	Help with transportation	3.31	0%	2.82	11
22	Clothing	3.32	0%	3.40	31
23	Personal hygiene (shower, haircut, etc.)	3.36	0%	3.21	26
24	Family counseling	3.42	0%	2.85	12
25	Treatment for dual diagnosis	3.45	3%	3.01	18
26	Detoxification from substances	3.46	6%	3.11	22
27	TB treatment	3.5	0%	3.45	33
28	AIDS/HIV testing/counseling	3.59	0%	3.38	30
29	Spiritual	3.61	0%	3.30	27
30	Help with medication	3.64	3%	3.18	24
31	Food	3.74	10%	3.56	35
32	Hepatitis C testing	3.76	0%	3.41	32
33	Treatment for substance abuse	3.79	10%	3.30	28
34	Services for emotional or psychiatric problems	3.82	6%	3.20	25
35	TB testing	3.89	0%	3.58	36
36	Medical services	3.92	0%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.93	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.95	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.94	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.69	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.52	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.44	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.67	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.56	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.31	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.73	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.27	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.2	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.87	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.13	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.8	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.2	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.87	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.87	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Cincinnati, OH - 539 (Ft. Thomas, KY)

VISN 10

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 200

2. Point-in-time estimate of Veterans who are Chronically Homeless: 31

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **200** (point-in-time estimate of homeless veterans in service area) **X 17%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 89%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 31** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	500	85
Transitional Housing Beds	230	60
Permanent Housing Beds	75	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Our HUD VASH program is working with HUD to develop additional long term housing options and/or increase vouchers. One of our Grant and Per Diem sites is developing community partners for housing.
Help with finding a job or getting employment	We will work closer with our Compensated Work Therapy program to develop process for more jobs for veterans. We will work more closely with Goodwill on collaborating in ways to make more employment opportunities for unemployed veterans.
Job Training	Goodwill has recently been awarded funding to assist veterans. Our program plans to work with Goodwill to maximize employment training opportunities for veterans in need.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 20 Non-VA staff Participants: 65%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	2.42	58%	2.25	1
2	Legal assistance	2.56	0%	2.61	4
3	Child care	2.63	0%	2.39	3
4	Help managing money	2.83	0%	2.71	7
5	Discharge upgrade	3.05	0%	2.90	15
6	Detoxification from substances	3.11	11%	3.11	22
7	Job training	3.15	21%	2.88	14
8	Welfare payments	3.18	0%	2.97	16
9	Dental care	3.2	11%	2.34	2
10	Emergency (immediate) shelter	3.21	11%	3.04	20
11	Guardianship (financial)	3.21	0%	2.76	9
12	Education	3.26	11%	2.88	13
13	Help with transportation	3.28	5%	2.82	11
14	Glasses	3.33	0%	2.67	6
15	Personal hygiene (shower, haircut, etc.)	3.35	5%	3.21	26
16	Halfway house or transitional living facility	3.37	16%	2.76	8
17	Eye care	3.42	0%	2.65	5
18	Help getting needed documents or identification	3.47	0%	3.16	23
19	Family counseling	3.55	0%	2.85	12
20	Drop-in center or day program	3.58	0%	2.77	10
21	Women's health care	3.6	0%	3.09	21
22	Help with finding a job or getting employment	3.63	21%	3.00	17
23	Treatment for dual diagnosis	3.65	11%	3.01	18
24	Help with medication	3.65	0%	3.18	24
25	Services for emotional or psychiatric problems	3.75	0%	3.20	25
26	SSI/SSD process	3.79	10%	3.02	19
27	Clothing	3.8	0%	3.40	31
28	Hepatitis C testing	3.8	0%	3.41	32
29	Treatment for substance abuse	3.85	0%	3.30	28
30	AIDS/HIV testing/counseling	3.85	0%	3.38	30
31	Food	4	5%	3.56	35
32	TB treatment	4	0%	3.45	33
33	Spiritual	4	0%	3.30	27
34	VA disability/pension	4.05	0%	3.33	29
35	TB testing	4.1	0%	3.58	36
36	Medical services	4.21	5%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.9	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.75	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.9	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.5	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.3	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.26	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.05	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.94	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.69	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.5	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.81	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.47	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.5	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.38	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.07	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.33	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.27	1.84

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CHALENG 2004 Survey: VAMC Cleveland, OH - 541, (Brecksville, OH)

VISN 10

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1250

2. Point-in-time estimate of Veterans who are Chronically Homeless: 162

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1250** (point-in-time estimate of homeless veterans in service area) **X 15%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 87%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 162** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	700	150
Transitional Housing Beds	620	30
Permanent Housing Beds	800	600

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 30

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Cleveland VA staff are participating in the local "Housing First" Initiative which is a collaboration of community social service providers, business leaders, funders and advocates who are developing permanent housing projects with supportive services on site. We have VA representation on the HUD Shelter Plus Care advisory board to ensure veterans access to the program.
Transitional living facility	Continue collaboration with local transitional housing programs to ensure appropriate referrals. Provide potential community partners with information about possible Grant and Per Diem funding opportunities. Continue VA representation on County Advisory Board for Homeless Services as well as local HUD Continuum of Care committee.
Help with finding a job or getting employment	Continued collaboration with Compensated Work Therapy program. Continue referrals to local One Stop Career Center. Continued collaboration with local Volunteer of America and HVRP program.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 20 Non-VA staff Participants: 95%
Homeless/Formerly Homeless: 5%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Long-term, permanent housing	1.95	32%	2.25	1
2	Child care	2.22	5%	2.39	3
3	Legal assistance	2.47	11%	2.61	4
4	Discharge upgrade	2.53	0%	2.90	15
5	Dental care	2.56	5%	2.34	2
6	Halfway house or transitional living facility	2.61	16%	2.76	8
7	Family counseling	2.71	0%	2.85	12
8	Guardianship (financial)	2.72	0%	2.76	9
9	Detoxification from substances	2.74	11%	3.11	22
10	Eye care	2.78	11%	2.65	5
11	Glasses	2.78	0%	2.67	6
12	Welfare payments	2.78	0%	2.97	16
13	Help getting needed documents or identification	2.88	16%	3.16	23
14	Drop-in center or day program	2.89	0%	2.77	10
15	Help managing money	2.89	0%	2.71	7
16	Help with finding a job or getting employment	2.89	11%	3.00	17
17	Treatment for dual diagnosis	2.94	16%	3.01	18
18	Women's health care	2.94	0%	3.09	21
19	SSI/SSD process	2.94	5%	3.02	19
20	Education	2.94	0%	2.88	13
21	Job training	3	5%	2.88	14
22	Help with transportation	3	5%	2.82	11
23	Spiritual	3	0%	3.30	27
24	Help with medication	3.05	0%	3.18	24
25	Treatment for substance abuse	3.17	21%	3.30	28
26	Personal hygiene (shower, haircut, etc.)	3.21	0%	3.21	26
27	Clothing	3.26	5%	3.40	31
28	Services for emotional or psychiatric problems	3.39	5%	3.20	25
29	Medical services	3.39	5%	3.55	34
30	VA disability/pension	3.39	5%	3.33	29
31	Emergency (immediate) shelter	3.44	11%	3.04	20
32	Hepatitis C testing	3.5	0%	3.41	32
33	TB treatment	3.56	0%	3.45	33
34	Food	3.63	0%	3.56	35
35	AIDS/HIV testing/counseling	3.67	0%	3.38	30
36	TB testing	3.89	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.89	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.42	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.21	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.56	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.26	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.53	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.59	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.72	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.11	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.89	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.17	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.78	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.95	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.79	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.83	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.67	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.89	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.94	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.89	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.16	1.84

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CHALENG 2004 Survey: VAMC Dayton, OH - 552

VISN 10

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 100

2. Point-in-time estimate of Veterans who are Chronically Homeless: 12

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **100** (point-in-time estimate of homeless veterans in service area) **X 16%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 76%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 12** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	134	87
Transitional Housing Beds	93	80
Permanent Housing Beds	25	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Emergency housing coalition members will be encouraged to apply for available grants.
Transitional living facility	Several agencies are preparing to apply for VA Grant and Per Diem funding in 2005.
Help with finding a job or getting employment	New Department of Labor grant received by VOA targets jobs for homeless.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 8 Non-VA staff Participants: 75%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Halfway house or transitional living facility	2.25	50%	2.76	8
2	Long-term, permanent housing	2.25	38%	2.25	1
3	Dental care	2.5	13%	2.34	2
4	Guardianship (financial)	2.63	0%	2.76	9
5	Help managing money	2.63	0%	2.71	7
6	Legal assistance	2.63	0%	2.61	4
7	Child care	2.86	0%	2.39	3
8	Eye care	2.88	13%	2.65	5
9	Job training	2.88	13%	2.88	14
10	Help with transportation	2.88	0%	2.82	11
11	Glasses	3	0%	2.67	6
12	Welfare payments	3	0%	2.97	16
13	Help with finding a job or getting employment	3	13%	3.00	17
14	Discharge upgrade	3	0%	2.90	15
15	SSI/SSD process	3.13	0%	3.02	19
16	Spiritual	3.13	0%	3.30	27
17	Treatment for dual diagnosis	3.25	13%	3.01	18
18	Family counseling	3.25	13%	2.85	12
19	Education	3.25	0%	2.88	13
20	Emergency (immediate) shelter	3.38	0%	3.04	20
21	Clothing	3.5	0%	3.40	31
22	Detoxification from substances	3.5	0%	3.11	22
23	Food	3.63	0%	3.56	35
24	Treatment for substance abuse	3.63	25%	3.30	28
25	Services for emotional or psychiatric problems	3.63	0%	3.20	25
26	Drop-in center or day program	3.63	0%	2.77	10
27	Women's health care	3.71	0%	3.09	21
28	VA disability/pension	3.71	0%	3.33	29
29	Help with medication	3.75	0%	3.18	24
30	Help getting needed documents or identification	3.75	0%	3.16	23
31	Personal hygiene (shower, haircut, etc.)	3.88	0%	3.21	26
32	AIDS/HIV testing/counseling	3.88	0%	3.38	30
33	TB testing	3.88	0%	3.58	36
34	Hepatitis C testing	3.88	0%	3.41	32
35	TB treatment	4	0%	3.45	33
36	Medical services	4.25	13%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.63	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.63	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.38	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.88	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.5	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.63	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.88	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.17	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.17	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.67	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.17	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.17	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.83	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.33	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.67	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.33	1.84

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CHALENG 2004 Survey: VAOPC Columbus, OH - 757, (Grove City, OH)

VISN 10

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 131

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **500** (point-in-time estimate of homeless veterans in service area) **X 33%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 78%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 131** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	325	100
Transitional Housing Beds	24	50
Permanent Housing Beds	30	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	A community agency continues to develop plans and implementation of a new family shelter. Funding, approval from neighborhood commission and neighborhood agreements are currently being developed.
Help with finding a job or getting employment	CWT vocational rehabilitation specialist plans to improve coordination of services with HVRP staff by identifying increased resources. Vocational rehabilitation specialist plans to increase transitional work experiences for veterans.
Long-term, permanent housing	CICH is a new initiative that started 12/03 and houses chronically homeless and mentally ill persons. CICH is a collaborative effort among five area agencies including VA.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 29 Non-VA staff Participants: 86%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Emergency (immediate) shelter	2.34	19%	3.04	20
2	Halfway house or transitional living facility	2.34	15%	2.76	8
3	Drop-in center or day program	2.43	0%	2.77	10
4	Child care	2.44	0%	2.39	3
5	Long-term, permanent housing	2.48	22%	2.25	1
6	Dental care	2.62	0%	2.34	2
7	Help with transportation	2.62	4%	2.82	11
8	Job training	2.66	11%	2.88	14
9	Eye care	2.69	0%	2.65	5
10	Glasses	2.69	0%	2.67	6
11	Discharge upgrade	2.7	4%	2.90	15
12	Legal assistance	2.72	0%	2.61	4
13	Education	2.75	7%	2.88	13
14	Detoxification from substances	2.83	0%	3.11	22
15	Help with finding a job or getting employment	2.83	15%	3.00	17
16	Family counseling	2.86	4%	2.85	12
17	Help with medication	2.9	22%	3.18	24
18	Welfare payments	2.9	0%	2.97	16
19	Help getting needed documents or identification	2.9	11%	3.16	23
20	SSI/SSD process	2.93	7%	3.02	19
21	Help managing money	2.93	0%	2.71	7
22	Spiritual	2.96	0%	3.30	27
23	Women's health care	3	11%	3.09	21
24	AIDS/HIV testing/counseling	3	4%	3.38	30
25	Personal hygiene (shower, haircut, etc.)	3.03	0%	3.21	26
26	Treatment for substance abuse	3.03	4%	3.30	28
27	Hepatitis C testing	3.04	0%	3.41	32
28	Guardianship (financial)	3.07	0%	2.76	9
29	VA disability/pension	3.14	4%	3.33	29
30	Treatment for dual diagnosis	3.17	0%	3.01	18
31	Clothing	3.24	0%	3.40	31
32	Medical services	3.24	15%	3.55	34
33	Services for emotional or psychiatric problems	3.28	11%	3.20	25
34	Food	3.31	4%	3.56	35
35	TB treatment	3.66	0%	3.45	33
36	TB testing	3.69	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.18	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.86	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.25	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.82	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.36	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.54	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.29	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.21	3.64

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Co-location of Services - Services from the VA and your agency provided in one location.	1.88	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.75	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.22	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.71	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.83	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.58	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.92	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.67	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.79	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.75	1.77
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